Hospital Inpatient Quality Reporting (IQR) Program

Support Contractor

Improving the Patient Experience of Care

Presentation Transcript

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Bethany Wheeler-Bunch: Hello and welcome to the Improving the Patient Experience and Care Webinar. My name is Bethany Wheeler-Bunch and I'm the Hospital Value-Based Purchasing Program Lead at the Hospital Inpatient VIQR Support Contractor. And I will be the moderator for today's event. Before we begin, I'd like to make our first few regular announcements. This program is being recorded. A transcript of the presentation, along with the questions and answers will be posted to the inpatient website, www.QualityReportingCenter.com in the upcoming weeks. If you registered for this event, a reminder email and the slides were sent out to your email about two hours ago. If you didn't receive the email, you can download slides at our inpatient website at www.QualityReportingCenter.com. If you have a question as we move through the webinar, please type your question into the chat window with the slide number associated, and we will answer as many questions as time allows. Any questions that are not answered during the webinar, will be posted to QualityReportingCenter.com in the upcoming week.

Now I would like to welcome today's guest presenters. And we have quite a few of them today. Thank you to you all for agreeing to present some of your knowledge and experiences on today's call.

This presentation will provide an overview of activities and best practices for improving the patient experience of care. CMS will present an overview of the Hospital Consumer Assessment of Healthcare Providers and Systems Survey, otherwise known as HCAHPS. Representatives from Jennings American Legion Hospital, along with the West Virginia University Medicine United Hospital Center, will share their experiences improving HCAHPS survey rates in their hospitals, the Quality Insights Quality Innovation Network, Quality Improvement Organization, will offer improvement strategies. Additionally, teams from the Beneficiary and Family Centered Care, QIO, and the Beneficiary and Family Centered Care Oversight and Review Center, along with the National Coordinating Center, will present an overview of the Beneficiary Satisfaction Survey, trends from the survey and experiences and knowledge gained from hearing directly from the patients.

Participants will be able to recall the background of the HCAHPS survey and the Beneficiary Satisfaction Survey, begin initiatives and activities to improve the patient experience, and identify tools to achieve measurement goals.

Without further ado, I would like to welcome our first speaker. Dr. William Lehrman is the government task lead for the HCAHPS survey at CMS. Dr. Lehrman, the floor is yours.

Dr. William Lehrman: Thank you. I'd like to talk a bit about the background of the HCAHPS survey. Let's begin with the name. The official name of the survey is the CAHPS® Hospital Survey, but it's also known as Hospital CAHPS® or more commonly as HCAHPS. Now, that stands for Hospital Consumer Assessment of Healthcare Providers and Systems, and we pronounce it, as I just mentioned, as H-CAHPS. I'd like to note that CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality, another US government agency.

Let's begin with the objectives of the HCAHP survey. There are four main objectives. First of all, HCAHPS standardizes data collection of hospital inpatient experience. Secondly, HCAHPS creates a common metric for patient experience of care across all participating hospitals, which allows comparisons across all hospitals through the mechanism of public reporting of HCAHPS scores. Thirdly, HCAHPS represents a new incentive for quality improvement for hospitals, and motivates we believe, more quality improvement in hospitals. And finally, HCAHPS enhances public accountability of hospitals and healthcare, and also addresses one of the goals of the National Quality Strategy.

Let’s talk a bit about the method of HCAHPS in very simple terms. First of all, we ask patients about their experience. That is, we survey patients. We collect information in a standardized and a consistent manner across all participating hospitals and across time. Once we've collected all the data, we adjust it for survey mode and patient mix factors and analyze results. And then we publicly report hospital results on our *Hospital Compare* website. And as I mentioned before, we believe this helps to

motivate improvement in quality of care. Let me also note that the HCAHPS survey asks only what patients know. They ask about the patient's individual experience in the hospital, because we believe the patient experience is a fundamental aspect of healthcare and a distinct dimension of quality. However, even though it's distinct, many researchers have found that hospitals that do well on HCAHPS, that is on patient experience, also do well in clinical measures, resubmissions, outcomes, mortality, et cetera. So, there's a lot of published literature that indicates that patients have a unique view into the quality of hospital care and that their view often comports with clinical outcomes and other measures.

Next, I'd like to talk a bit about the evolving scope of the HCAHPS survey. When HCAHPS was first implemented, hospital participation was completely voluntary. That was back in 2006. Shortly thereafter, HCAHPS was included in the pay for reporting program for the Hospital Inpatient Quality Reporting Program as it's known now, for Inpatient Prospective Payment System hospitals, or IPPS hospitals. That occurred in 2007. And at that point in time, 2% of the annual payment update for these hospitals was at risk if hospitals did not report all of the required measures, which included HCAHPS. Then in 2012, HCAHPS was included as one of the first measures in the Hospital Value-Based Purchasing Program, or VBP Program, which is a pay for performance program for IPPS hospitals, which was instituted under the Patient Protection and Affordable Care Act of 2010.

In this slide, we discuss the composition of HCAHP survey. The HCAHPS survey is fairly short. It's only 32 items. These 32 items are broken into two groups. The first 25 items are the core HCAHPS survey. They must be at the beginning of the survey. No HCAHPS items can be altered in any way, and these first 25 items must be kept together, that is given in sequence to the respondent. The 25 items consist of 21 substantive items about the patients' experience of care in a hospital, and then also four screener items to direct patients to correct items to answer. The second set of questions we call the "About You" questions. There are seven of these. They follow the core questions. And like the core

questions, they must be kept together in a sequence and not altered in any way. However, hospitals are permitted to put their own supplemental items between the core items and the "About You" items.

There are 11 publicly reported HCAHPS measures that are created from the HCAHPS survey. There are three types of measures, composite measures, individual items, and global items. Turning first to the seven composite measures. You can see here, the list of measures that are created from two or three items in the survey. I should note here, with respect to pain management, that the pain management measure will be reported only through the October 2018 public reporting. Beginning with the December 2018 public reporting, the pain management measure will be removed from *Hospital Compare*. There also two individual items, that is an item made from just one question on the survey. These two items address, the cleanliness, and the quietness of the hospital environment. Finally, there are two global items. Like the individual items, these are comprised of just one survey question. One question asked the patient whether they would recommend the hospital to family and friends, and the other asked the patient their overall rating of the hospital based upon this hospital stay.

Here I'm displaying the trends of the HCAHPS measures since 2009. There are a couple of things to note here. First of all, all of the measures have increased over time. And specifically, these are HCAHPS top box scores that is the most positive response to HCAHPS measures or items in the survey. So, we can see over time, that all of the measures have been increasing. The top box scores have been increasing. We can also note that sort of the ordering of the measures stays pretty much the same. Discharge information has the highest top box score, though in part that's an artifact of the nature of the discharge item. It's comprised of two yes/no survey items. The next highest composite measure is communication with doctors. And at the other end, the lowest measure is quietness. And pretty much the rank order amongst all the measures has stayed consistent across time.

I'd like to say a few words about the pervasiveness of the HCAHPS survey. I call it, "HCAHPS Never Rests." In the April 2018 public reporting on *Hospital Compare*, HCAHPS scores will be based upon more than 3.0 million completed surveys from patients at over 4,300 hospitals. Looked at another way, every day more than 8,200 patients complete the HCAHPS survey. HCAHPS is also used in other programs. I've already mentioned the Hospital IQR Program and Hospital Value-Based Purchasing Program. The HCAHPS survey is also a component of the *Hospital Compare* Overall Star Ratings on *Hospital Compare*. And HCAHPS scores are used in other CMS programs, such as the Comprehensive Care for Joint Replacement Program.

Here are three sources for more information about the HCAHPS survey. Our HCAHPS online website, where we provide statistical information about the survey, as well as news, and also the survey forms. To get information about how to submit HCAHPS data to the warehouse, please use the *QualityNet* link. And to see HCAHPS publicly reported scores. Here is the link for *Hospital Compare*.

A few more words about our own HCAHPS website, HCAHPS Online. This is a list of some of the information that's available on this website, and we think it's a very important resource for hospitals, survey vendors and anybody who's interested in how well hospitals are doing on the HCAHPS survey. Now back to our host.

Bethany Wheeler-Bunch: Thank you, Dr. Lehrman for your overview of the HCAHPS survey. Now I would like to welcome our next speaker, Dawn Strawser. Dawn is the Network Task Lead for Quality Improvement Through Quality Reporting Programs at the Quality Insight QIN-QIO for the states of Delaware, Louisiana, New Jersey, Pennsylvania, and West Virginia. Dawn, the floor is yours.

Dawn Strawser: Thank you, Bethany. I'm going to start on Slide 20. My first few slides will introduce who Quality Insights is and what we do.

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Per the insights of the QIN-QIO, which stands for Quality Innovation Network, Quality Improvement Organization. QIN-QIOs are contracted by the Centers for Medicare and Medicaid Services to work with facilities, providers, and beneficiaries to improve the quality of care focusing on national and local quality priorities.

Quality Insights is a five state QIN-QIO and includes the states of Delaware, Louisiana, New Jersey, Pennsylvania, and West Virginia. We are in the fourth year of a five-year contract.

This slide is for you to refer to for the principles of priorities of the QIN-QIO program's approach to clinical quality. You can refer to this slide later.

The task I work on is quality improvement through quality reporting programs. We work with the ambulatory surgery centers, critical access hospitals, and inpatient psychiatric facilities, hospitals and the cancer hospital located in Pennsylvania. There are 175 facilities in our Learning and Action Network, providing technical assistance to providers to improve on measures associated with the various quality reporting programs.

On the previous presentation, you heard what HCAHPS stands for, and all about the background of the HCAHPS survey. This slide includes a link to *Hospital Compare* where you can type in your hospital's name and click on survey of patients experience to view your rates compared to your state and national rates.

For fiscal year 2020, the person and community engagement domain are 25% of the total value-based purchasing score. The baseline time period is calendar year 2016, with the performance time period being calendar year 2018. I will go through each of the survey dimensions with some strategies and best practices for improvement. And this slide mentions the survey dimensions included in fiscal year 2020, as you heard on the previous presentation.

Some best practices to improve the 'communication with nurses' HCAHPS questions, would include leadership rounds and purposeful rounding. To make the leadership rounds more purposeful, they need to be consistent. They need to have a specific plan about how and when it will be done. You need to establish key questions that we ask every patient and family, follow up quickly on identified problems, recognize the work of the staff, and track the trends and patients' comments and questions. The four Ps are key elements for the bedside nurses hourly rounding. Pain: Ask the patient if they're in pain or check to see if it's time for the next dose of analgesics. Potty: Consider this especially with the elderly or those on diuretics or fluid replacement. Position: Changing the patient's position can alleviate pressure, pain, or soreness. And Placement: When you're placing the patient, be sure they can still reach the call light, the remote control, their glasses, their tissues, their bedpan if needed. These five items are the most frequently requested needs for the patients, which use our call lights. Also, nurses should use teach back, an active listening, education, and communication techniques. Teach back will be discussed further into the presentation. Active listening involves making a conscious effort to hear not only the words that another person is saying, but more importantly, understanding the complete message being sent by the patient. Remember, that for the majority of the patients, they see anyone wearing scrubs, as a nurse. So, interventions put in place to improve nurse communication should be shared with everyone that could be perceived as being a nurse.

Here are just a few examples of ways to help your staff promote the positive behaviors and how to use your medical staff. In the emergency room, the nurse can say, "Dr. Jones will be with you soon. She's really great with kids." On the patient care unit, the aide or nurse can say, "I see Dr. Peterson will be stopping by for your cardiology consult. He's very thorough." In radiology, where invasive procedures are performed, the technologist can say, "Dr. Hai will be right here. You'll find him to be very sensitive about properly addressing any pain you may experience during the procedure." Be sure to communicate delays to the patients and

their families. Share the HCAHPS questions and results with the physicians and hold them accountable.

Best practices to improve the responsiveness of hospital staff dimension include proactive communication. And this can be done with your hourly rounding. This is effective in reducing the use of call lights. Be sure to address the four Ps as mentioned earlier in the hourly rounding. Be consistent. If rounding isn't done hourly, the patients will lose confidence that somebody will be stopping in and start to use the call bells. The “No Passing” zone means that a staff member does not walk by the room without going in and asking the patient what they need assistance for. They may not be able to help the patient and have to get help from another staff member, but the patient will feel that the call bell was answered quickly. Focus on employee satisfaction. Happy employees make for happy patients. Another strategy could be utilizing cell phones for staff. The patients call the nurses directly on their cell phones instead of ringing their call bell. Be sure to share data with all levels of your organization.

Patients need to know the names of their medications, purpose, dosage, and side effects. This should be explained to the patient prior to the first time the medication is administered. Using teach back, you will ask the patient to repeat in her own words what you reviewed with them. Teach back will give you a chance to check for understanding and reteach if needed. Medication teaching should also be done at discharge. Having pharmacy make rounds for teaching, involving caregivers in the teaching, and providing medication cards are the other ways to improve upon communication about medication.

Cleanliness isn't just the responsibility of the environmental services staff. It’s everyone's responsibility. Specific actions for environmental service staff can be at the beginning of a shift. They can introduce themselves to each patient, empty the trash cans at that time and discuss an appropriate time to clean the room. Providing the name and number of the environmental service staff on a whiteboard, will also provide that extra reassurance to the patient, that they know who to reach if they need something cleaned. Asking patients when leaving the room if the room

meets their cleanliness standards and if they would like anything else cleaned. For all others in contact with patients, reinforce cleanliness by emptying wastebaskets multiple times a day, and offering to change sheets. Including environmental services on unit teams and increasing the frequency of non-daily cleanliness, such a waxing the floor or washing the walls, will also have a positive impact.

Actions to address: Quietness include providing patients with a welcome kit during admission that contains ear plugs and eye covers, which will emphasize that we want you to have a good night's sleep. Fixing squeaking wheels on carts, dimming the lights, oil the door hinges, turning the phone ringers down, and making no overhead announcements, will also emphasize quietness. Also having secret shoppers do noise audits at night to monitor noise levels and identify improvement opportunities. Also having staff use keywords with their actions, such as “I’m shutting your door for privacy and to reduce noise disturbances.”

Using a discharge folder that contains medication information, prescriptions, written discharge instructions, follow up appointment details, important names, and phone numbers, will be beneficial for the patients to refer to upon discharge. Other actions to improve on discharge information include having effective medication education and reconciliation. Making follow up appointments prior to discharge and doing post discharge phone calls to assess patients’ self-care knowledge and to reinforce patient education.

Besides improving the patient experience, improving care transitions will also assist with decreasing readmissions, improve communication with patients before and after discharge. And this slide also lists some things, pre-discharge, post discharge and bridging that you can utilize.

There are two HCAHPS dimensions that are highly correlated with the overall rating of hospital. Their nurse communication and responsiveness of staff. Using interventions to improve these dimensions will correlate with the higher rating of hospital. Adding patient and or family members to your hospital's improvement teams, will bring the patient perspective to

how to improve to the team. Patient and family engagement is a powerful component to improving the hospital's improvement efforts.

We are all the patient experience. This video is approximately four minutes long, and it's a great video to show your staff. Additional resources and references are provided on the remaining two sides. I'm going to go ahead and play the video for you now.

And now back to Bethany.

Bethany Wheeler-Bunch: Thank you, Dawn. We will now move into our two hospital presentations. Our first presentation is from Stephanie Smart. Stephanie is the Vice President of Nursing and the Chief Nursing Officer of West Virginia University United Hospital Center. Stephanie, the floor is yours.

Stephanie Smart: Thank you, Bethany. Today I'm going to talk about some best practices that we have implemented in our hospital.

Our setting is a not-for-profit community hospital. We have 292 licensed beds with an array of services, inpatient and outpatient both. We have close to 2,000 active employees, with 158 active medical staff. We have a large volunteer program with close to 150 volunteers. We do close to 1,100 births a year. We have one of the busiest emergency departments in the state with almost 55,000 visits last year. And we do close to 14,000 annual admissions.

Other services include medical/surgical oncology. We have behavioral health. We do cardiovascular PCIs. We have a large home health and hospice program as well.

So today I wanted to go over our hourly rounding and patient communication program that we have recently implemented. And it's called, "Just Say Hello." The reason "Just Say Hello" is what we decided to term this program, is because we put together a frontline staff-based council for patient satisfaction. We historically as an organization, have performed in outstanding ways surrounded around quality and patient safety, but we just weren't quite able to move the needle with patient

satisfaction, which as an executive, was kind of perplexing to me. And so, what we decided is we need to ask the staff what they think that we could be and should be doing maybe better.

When we did that, what we decided is, it's really pretty simple and we needed to go back and visit the basics. So, patients want kindness. They want communication. They want a connection with the staff, and they want empathy. We worry a lot about patients' needs. That's what we're taught. That's what we do every day, but the patients' wants may not necessarily be the same as what their needs are. And we were maybe missing that part of patient care.

"Just Say Hello" is a communication method for the staff to talk to our patients in a way that the patients understand, in a way that they perceive us to have the time to individualize their care. And you can see here, these are badges that we made that the staff carry around with them every day, along with their ID badges, that explain to the staff and help remind the staff, what do we say to patients? And not only what do we say to the patients, but how do we say those things? For instance, the word "hello" is very meaningful now in our organization. We don't say, "Hi." We don't say "Hey." We say, "Hello." It's professional. It's meaningful. The patients will never perceive that as being unprofessional or rude or rash.

We want to make sure that the clinical staff are responsible to make sure that the hourly rounding is accomplished. And we wanted to also make sure that hourly rounding, although it is a goal, it's really about what and how we say things when we're in our patients' rooms.

So patient perception is huge, and we always like to say in our organization, "Perception is everything." Your intent really does not matter. And I think that is a great statement for them to carry around with them. And as we have taught our self, you know, we need to be able to read our patients. If someone looks lost, you know, we know that they look lost. Offer to give them directions. Don't just walk down the hallway. Little, low hanging fruit. Overflowing trashcans. Extra linens laying around. We need to be tidying up the rooms. Again, the room could be

spick and span and it could have been cleaned three times that day but, you know, it's the patient's perception, really, that matters. So, if we have trashcans that are full, or we have things laying around and the room is untidy, then the patient's perception is going to be that the environment is not clean.

So, when we talk about "Hello," we want to make sure that the staff are introducing themselves and they're explaining their title, and how they're going to be assisting in their care. This is big. We have colors in our hospital that every staff member wears. And I always joke with the new staff and explain to them, you know, I ask them, why do you think that we organized the color of scrubs that we wear? And immediately say, "Well, so the patients know who we are and what type of staff member we are." And of course, that was the intent in the beginning, but what we soon came to realize is that patients, they have no clue about that. It's really for the staff. So again, perception is huge. And also, the staff need to make sure that they are explaining who they are and what they are doing every time that they go into the room, because the patients do not have any idea about that.

"Explain," which is the E for our "Just Say Hello." We want to make sure that the patients know what is going on with their care. We want to explain it to them and not only in medical terms. We need to explain it in a way that the patients understand what we're saying.

"Learn." We want to teach patients all the time. We want to teach them new education. We want to teach them about things that we already think maybe they know, because it's a chronic illness. And we want to make sure that again, we're making that connection with the patients. We want to help them understand what their needs are, because the patients most moments, only know what their wants are. We have to help them figure out what those needs are.

We want to "Listen" to our patients. Again, making a connection. We want to give them opportunity to ask questions. We don't want to just give them the opportunity to ask questions. We want to help them ask questions

and maybe give them suggestions for the questions that they should be asking.

And then of course, we want to "Offer." This is the hourly rounding piece, but it's funny because when we talk about hourly rounding, everyone, I think in their minds, thinks of being in the patient's room every hour, which is important. But everything else that I talked about with "Just Say Hello" is just as important as the hourly round, because we can be in and out of our patients room every hour, but if we're not making connections and we're not educating our patients on their needs and their wants, then patient satisfaction is not going to be where we think that it should be. So "Offer." Before we leave the room, we want to ask the patient, "Is there anything else we can do for them?" We want to make suggestions, "Could I take you to the restroom? Could I get you something to drink?" You know, "Could I," you know, "plug your cellphone in and charge it for you?" These things are very important for the patient.

Again, making sure that we do everything while we're in that room before we leave, so in return the patient doesn't have to ring their call light. And also, the staff are decreasing their time and steps up and down hallways, in and out of rooms getting things for the patients that they could have gotten for them when they were in the room, if they would have just made those suggestions.

And then of course we have our different items for hourly rounding. Everyone has in practice different things that they do for hourly rounding in our organization. Our staff picked five. We have: Pain, Potty, Possessions, Position and Plug-ins. Plug-ins is kind of a new one because of all the technology everyone has now. So, it's something that maybe staff haven't always thought about. So, this is something new that we have explained to them because everything now in a hospital plugs in essentially.

Pain and potty; again, we need to suggest that. We offer restroom before we leave the room.

Positioning; we want to make sure that we don't just ask the patient, are you okay? Are you comfortable? We want to suggest doing things for them. We want to offer extra blankets and pillows. We want to offer to move them in a more comfortable position in the bed.

Possessions; again, we need to tidy the room. We need to move everything close to the patient so they're not getting out of the bed to try to get things and in return falling, or again ringing the call light for someone to come back.

Plug-ins; not only do the hospital items plug in, so do, you know, patients now, they bring stuff with them. They bring cellphones. They bring iPads. They bring laptops. So, we need to make sure that it's not just medical devices that we're plugging in. We need to make sure that the patients' personal items also don't need plugging in.

And you can see our results so far have been fantastic. We finished the year in 2017 at 71.2. And you can see 2016 actually we were at 68.8. And so far in 2018 we're at 77.3%, which is a huge increase in overall rate, the hospital patient satisfaction. So, so far, our implementation has been very successful.

So, in conclusion, I love this quote, "I've learned that people will forget what you said. People will forget what you did, but people will never forget how you made them feel." And this is really the piece that we were missing. Our staff were saying all the right things and they were doing all the right things and they were in the rooms doing hourly rounding. Probably they were in the rooms more than every hour, but we weren't talking to the patients in a way that we made them feel cared for and made them feel like we had time for them. So really that's the piece that we're changing and that we have changed with this program. And it's working, and my hope is that it will continue to work.

And now I'll pass this back to Bethany.

Bethany Wheeler-Bunch: Thank you, Stephanie. Our next hospital presentation is from Brooke Hornsby and Allison Fields. Brooke is the Chief Nursing Officer and

Allison is a Clinical Educator at Jennings American Legion Hospital. Brooke and Allison, the floor is yours.

Allison Fields: Thank you for allowing us to share with you our successes. Jennings American Legion Hospital is a 49-bed rural hospital located in southwest Louisiana. We opened our doors in 1952 as a non-profit hospital, with the assistance of the American Legion members in our community. We are currently the only American Legion hospital still operating in the country, and we are very proud to still have American Legion members on our board. We service several rural areas around us, and our services include ER, ICU, med/surg, surgery, OB, path lab, and three rural health clinics and one surgery clinic.

As we get started today, we're excited to talk about our improvement in our top box scores. We looked at fourth quarter ‘15 and third quarter ‘16, compared to fourth quarter ‘16, to third quarter ‘17. We use HealthSpring’s phone survey to collect our data. As you can see, our nurse communications went up from 84 to 87. Communication about medications went from 72 to 76, and discharge information went from 90 to 92. We are extremely proud to have our HCAHPS summary score move from a four to a five-star rating.

Our goal is transparency throughout the organization. We begin with all new hires at orientation. Our COO actually discusses HCAHPS and sets the expectation for our employees. Our COO also reports our results at every level, from the hospital, from leadership meetings where our managers bring the scores to their staff, to our performance improvement team, to med staff, and to our governing board. Multiple areas are surveyed throughout the hospital, including our ED, ancillary departments, outpatient surgery and clinics. Our hospital-wide focus is what we will be talking about today. I will now let Brooke discuss some other nursing strategies that we use to increase our scores.

Brooke Hornsby: One reason we feel that nurse communication has improved is by implementing our standardized bedside shift report in all nursing departments. This has not been an easy process to implement, but in the

most recent years, we pulled a team of frontline staff. We educated them on the importance of nurse communication and involving the patient at the bedside. We empowered them to improve our bedside shift report and the process. At first, they were using a computerized generated report sheet, which left off a lot of information they felt was important. So, we actually brought back a handwritten report sheet to use at the bedside. The next thing we did was trialed on one unit to perfect the flow. We made adjustments as we saw needed. Once we finalized and the staff felt that this was perfected, we educated each member of our team by role playing, and the process was launched out to multiple departments. We started monitoring, Allison and myself. Once we felt that this process was hardwired, we delegated it back to their charge nurses on the towers and the managers of the ICU and the OB Departments. We continue this monitoring by direct observation. Now we are expanding this bedside shift report to our CNAs in other departments, including our Emergency Departments and our Surgery Departments.

What you see here is a report sheet that is utilized by our Med/Surg Department. Each department was able to customize their own report sheet the way they saw it fitted their departments.

Here you see is our monitoring results for the fourth quarter of 2017. It includes our Med/Surg Department and our OB Departments. We post these results on each department, so they can see where they need improvement, and this also is part of our transparency. This is also brought to multiple performance improvement teams.

Our next initiative we brought forth was creating 24/7 permanent charge nurse positions for our med/surg units. To get their input, we decided that we would have the charge nurses meet quarterly to review with HCAHPS and other quality measures. These meetings included our day and night shift charge nurses, as well as Allison and myself. In these meetings, we came up with action plans to improve our HCAHPS results. The charge nurses were empowered to come up with their own action plans that would fit in each of their departments. One of the things that they decided to do was to round on all patients. These charge nurse rounds were based on

previous HCAHPS results. Some of the questions included, “Did you find it was quiet at night?” Or “How was your pain handled?” I will now turn it back over to Allison who will discuss some of our discharge information and other contributing factors that we felt has increased our HCAHPS scores. Thank you.

Allison Fields: Thank you, Brooke. The third process that was implemented revolved around standardizing our discharge process. Discharge folders are given to each patient upon admission, and the folders remain in the patient's room to keep all of their education material together. Patients are educated by multiple caregivers, regarding their diagnosis, diet, and medication. All this information is available for the patient during their stay and is sent home with the patient when they are discharged so they can reference back to it when needed. Follow up appointments are made prior to discharge to follow up with their physicians to help with their continuum of care. Also, high risk patients are called back multiple times after discharge to ensure that they understand their discharge instructions, including their medication.

Other contributing factors that we find have helped increase our scores is our outpatient pharmacy, which allows our patients to have their medications filled before they go home. So, we can guarantee that they have what they were prescribed prior to discharge. This also gives our pharmacists an opportunity, as well, to educate the patients on their medication. Our strong primary care and hospital medicine programs, help to provide our patients with personalized care. The four hospital-based clinics help provide the patients with a smooth transition and continuum of care once they are discharged from the hospital. These processes that we have discussed, allows for continual patient satisfaction throughout our organization. Thank you for allowing us the opportunity to share our successes. And we will turn it back over to our host.

Bethany Wheeler-Bunch: Thank you so much for sharing your experiences. We will now be transitioning to the second half of our presentation, shifting our focus from the HCAHP survey to the Beneficiary Satisfaction Survey. Our first presenters are from the Beneficiary and Family Centered Care Oversight

and Review Center. Stephanie Fry is the analytic director. And Wendy Gary is a Director at the BFCC Oversight and Review Center. Ladies, the floor is now yours.

Wendy Gary: Thank you. The BFCC ORC is one of the CMS 11th Scope of Work Program components. We exist to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries by the BFCC-QIOs. Our overall objective in the ORC statement of work, is to provide consultation and survey program support services to assist in the development, administration, analysis and reporting on surveys of Medicare beneficiaries experience with services provided by the BFCC-QIOs. I would like to emphasize that the ORC is an independent oversight and review center that works towards QIO evaluation metrics. We collaborate with the BFCC-NCC to share data and provide and contribute to education and support to BFCC-QIOs. Stephanie?

Stephanie Fry: Thank you, Wendy. I'm going to take a couple of minutes today to describe the Beneficiary Satisfaction Survey administered by the BFCC ORC. To give you a little bit of background on the study, every month CMS fields a survey to beneficiaries, or their representatives, who contacted their BFCC-QIO for help or support. The findings from that survey help CMS and the QIOs to know about the experiences of these beneficiaries. As indicated by the envelopes, the survey is sent by mail and is sent in either English or Spanish at the beneficiaries' request. We also place calls to convey the importance of the survey and to answer any questions that beneficiaries may have. The survey asks beneficiaries to report on their experience accessing and communicating with QIOs, and the degree to which they felt the QIOs treated them with courtesy and respect. The survey also asks about beneficiaries' satisfaction with their overall experience working with the QIO.

The surveys are sent to beneficiaries who received BFCC-QIO services. And so, to reiterate, these are beneficiaries who contacted their QIO to file a complaint or an appeal. This includes those who engaged in a formal Quality of Care Complaint in which the QIO performs a medical record review to assess concerns about the quality of care of services. It also

includes individuals who chose to participate in the Immediate Advocacy process to address their concern. Finally, it includes beneficiaries who appealed a discharge or payment decision made by Medicare.

The Beneficiary Satisfaction Survey covers three main processes that include, beneficiary centered communications, courtesy and respect, and access and responsiveness, all elements describing beneficiary experience with the process of interacting with their QIO.

In context, you can see how this fits into a larger process where beneficiaries and family members provide their feedback through the satisfaction survey. The information from that satisfaction survey is reported out to the QIOs and to CMS. And they use that feedback to perform ongoing quality improvement initiatives, and in turn, improve the services that they provide to beneficiaries and families. Thank you. I'll turn it back to our host, Bethany now.

Bethany Wheeler-Bunch: Thank you for that overview. Our next speaker, Elena Krafft, is an Outreach Specialist at the Beneficiary and Family Centered Care National Coordinating Center at KEPRO. Elena, the floor is yours.

Elena Krafft: Yes. Thank you, Bethany. Today I'll be providing a general overview of the Beneficiary and Family Centered Care Quality Improvement Organization program, or the BFCC-QIO program. Following my presentation, Rita Bowling, Program Director for KEPRO, will also share recommendations for improving internal and external operations to ensure beneficiary satisfaction in the case review process.

Before we go into the specifics of the BFCC-QIO program, I wanted to share some information about the Beneficiary and Family Centered Care National Coordinating Center, or the BFCC-NCC. We serve as a support and training center for the BFCC-QIO program, providing the QIOs with continuous Medicare case review training, resources, and technical support. Additionally, the BFCC-NCC, overseas a number of national initiatives, including a beneficiary and family advisory council. The council consists of 16 Medicare beneficiaries and caregivers from across

the country, who provide personal perspectives and experiences to help guide the quality improvement and patient engagement efforts of the BFCC-NCC, and the BFCC-QIOs. The BFCC-NCC also conducts national outreach and education, partnering with Medicare stakeholders at the national level to increase awareness about the case review services that we will discuss today. Additionally, the BFCC-NCC is also working on person and family engagement projects aimed to encourage Medicare beneficiaries and their families to be more involved in their healthcare and foster improved case review experience for patients and their families. The link on the slide can provide you with additional information about the various BFCC-NCC initiatives.

This leads us into the main topic of my presentation today, which is the BFCC-QIO program. In short, the BFCC-QIOs work with CMS to help Medicare beneficiaries exercise their right to high quality healthcare. The services they provide include discharge appeals and service terminations, quality of care complaints, immediate advocacy, and more recently, healthcare navigation services.

In the next few slides, I will go over each of these services in more detail, and additional information can be found on our website by accessing the link on this slide.

As far as the structure of the BFCC-QIO program, two BFCC-QIOs, KEPRO and Livanta serve all 50 states, the District of Columbia and three territories, which as you can see here, are grouped into five areas. KEPRO serves areas two, three and four and Livanta serves areas one and five. Each area is associated with a different phone number as you can see here. The BFCC-QIOs are currently performing the 11th Scope of Work, which started August 1, of 2014 and ends July 17 of 2019.

As mentioned, one of the services provided by the BFCC-QIOs is discharge and service termination appeals. So BFCC-QIOs manage all cases in which beneficiaries want to appeal a healthcare provider's decision to discharge them from a hospital or discontinue other types of

services. A Medicare beneficiary can file an appeal by contacting the BFCC-QIO for their state.

BFCC-QIOs also help Medicare beneficiaries exercise their right to high quality healthcare, by handling all quality of care complaints. This is a formal Medicare complaint submitted by a Medicare beneficiary, or his or her representative, when there is a concern about the quality of care received. Some examples of concerns include, receiving the wrong medication, developing a hospital-acquired infection that was not treated, receiving incomplete or no discharge instructions, and not receiving care in a timely manner. A BFCC-QIO independent physician reviewer, will review the medical records to determine if the beneficiary received the proper care. If the result of the review is a confirmed concern, the BFCC-QIO will continue to investigate the matter and will work with the provider to prevent similar problems from reoccurring.

The third service I will be discussing is immediate advocacy. This is an informal process that BFCC-QIOs use to resolve a verbal complaint quickly. It can relate to services that accompany medical care, such as lack of communication by hospital staff, failure to receive a medical equipment, or difficulty getting a doctor's appointment.

And finally, more recently under the Person and Family Engagement Care Management Improvement Initiative, BFCC-QIOs began offering healthcare navigation services to connect beneficiaries and caregivers with resources and provide beneficiary and caregiver support in understanding the healthcare system. The ultimate goal of the beneficiary healthcare navigation service is for the BFCC-QIOs to provide care management for beneficiaries with complex healthcare needs to improve the quality and experience of care in an often complex healthcare continuum.

I will now turn the presentation over to Rita Bowling, who is the program director for KEPRO and she will discuss the insights gained from the beneficiary surveys. Rita?

Rita Bowling: Thank you, Elena. Looking at the survey, the Beneficiary Satisfaction Survey, I'm trying to make some sense out of the results. First of all, in just looking at these results, I have to say that the survey is anonymous. Therefore, we cannot connect the comments that are made, and the results, with any particular case. Therefore, we can't really go back and look at the context of a particular comment. We also cannot talk to individual employees about a particular thing, a particular comment or something that they might have said about a particular employee. So, in approaching this from a general perspective and looking for trends, I just have two comments that I want to first lay out for you from the results. First of all, beneficiaries or callers have great difficulty differentiating between quality of care and experience of care. Quality of care being what all of our case review activities are really founded on. So, we're looking at quality of care based on certain standards of care being met. From a patient's perspective, their experience of care is really based on their perception of what they're seeing, feeling, experiencing and so forth. Patients also cannot separate process from outcome in this survey. Although the questions are really geared to the process that we went through with the patients, the outcome definitely colors their results. If they perceive that anything is wrong along the way, then their comments are likely to be more negative.

So, in looking at this from a general standpoint, we decided that we could take a really close look at all of the internal operations that we do, that have some kind of contact with patients. If we could somehow make their experience of calling for an appeal or calling in for a quality of care complaint, smoother, less stressful, more positive, then there is a better likelihood that their comments are going to be more positive, in spite of what the determination of the outcome of the review might be. So, we have tried to take advantage of all of the conversations that we have with beneficiaries. We have been taking more time with a caller, looking for those teachable moments and giving them back some type of information or answering questions better, that sort of thing. We have been looking at our review processes and what the expectations are. We cover those with the patients so that they can try to understand better what's going to happen, what's the next step and so forth. One of the things that we have

done with our quality of care complaints is to put together a written document on the process. This type of review can take up to 30 days to complete, and the beneficiaries often get lost in that process. So, this document is sent out to them when they start their review. Then we can refer to it with them each time that we talk to them through that process. We have started referring callers immediately to our Navigation Program. With this program, if we can help turn their negative experiences into something that they understand what's happening better, they know what the next steps are going to be, we can even start coordinating things with their providers and with their family members so that they have a better transition to whatever that next step is. Maintain a continuous person-centered communication throughout the process. We try to get the patient to tell us what they're feeling, perceiving, understanding, and then we use that information to drive our approach in what we give them and what we can do for them. Many of the comments in the satisfaction surveys are not just geared to KEPRO or Livanta, like the BFCC-QIO as an entity with our process. Many of them also comment on their providers and other organizations that they're dealing with in this whole experience of the appeal or the complaint. So, we came up with a few things that external operations can look at as well. First of all, there are many, many comments about discharge planning, and it appears that patients generally do not feel that they understand that their discharge planning is really in place, that people are doing things to help them. So, our first recommendation is really to look at your discharge planning, start it early, do it daily and constantly communicate what you're doing with the beneficiary. Secondly, give good explanations of what is happening and why. Too many people don't understand, you know, why something is being done or what's going to happen next. Give good explanations for an appeal or a complaint that they're trying to call in. They understand that they have a right to that as a Medicare beneficiary, but they oftentimes do not understand what they're doing, what they need to get out of it, what their expectations are of the results. And so, they really get lost in that whole approach. And what we found is that many providers also are giving misinformation to patients, because they don't really understand the appeal process either, or the complaint process as well. So, if there are

providers out there that would like some education or training on these processes, we would be glad to reach out and go through that with you. Now that we have our Navigation Program, there are many other navigation programs around as well, I would suggest that you refer patients to a navigation program early in the process so that your discharge planners and your case managers can take advantage of that continued navigation and continued support that you can give to your patients when they do go home. And again, I have to say external sources should also be providing continuous patient centered communication through process. Having them give you what they need and what they're experiencing and what they want, and then you communicate through various processes, and what you must get through to them, through that context. Continuing collaborative communication with the BFCC-QIO is also very helpful. If the three-way kind of communication can occur between the patient, the provider and the QIO, I think the experience of care could be much improved. Thank you. And I'll turn it back to Bethany.

Bethany Wheeler-Bunch: Thank you. Now we have time for some question and answers today. So, starting off, first question is for Dr. Lehrman. Are HCAHPS surveys anonymous?

Dr. William Lehrman: Hi. This is Bill Lehrman. Yes. The data that's reported to CMS is de-identified. So, CMS has no way to identify who the patient was, whose surveyed was submitted to us.

Bethany Wheeler-Bunch: Thank you. The next question is also for you Dr. Lehrman. How are the composite HCAHPS measures computed? What methodology is used to combine the multiple questions into one result?

Dr. William Lehrman: Okay. So, I mentioned earlier that there are, I think, seven composite measures in HCAHPS which are comprised of two or three separate items in the survey. So, the separate items in the composite say communication about nurses, each item is equally weighted. We combined the number of well, the four options for most items from always to never. And we combine those to get the score. Each item in the composite has equal weight, and then we combine those across all patients in the hospital to

create the score for each of the composite measures. I believe there's some information on HCAHPS online website about more detailed information about how to calculate scores. Or you can write to the HCAHPS technical assistance help desk for more information on that as well.

Bethany Wheeler-Bunch: Great. Thank you, Dr. Lehrman. Our next question is for Dawn Strawser. On slide 27, you mentioned leadership rounds. Would you be able to define leadership?

Dawn Strawser: Hi. Yes. This is Dawn. The hospital can define who to include on the leadership rounds, but ideally the C-Suite needs to be included. Even if they all can't be there, if they can get a schedule and at least one of them be present on the leadership rounds, it really is ideal for the patients to see that the C-Suite is involved. But the CEO, CFO, CMO, the COO, you can include the Director of Quality and also your Patient Safety Officer, Nurse Managers. So, it would be great if you could set up a schedule, maybe four people in the rounds at one time, but mainly, you know, try to get the C-Suite involved.

Bethany Wheeler-Bunch: Thank you. On slide 29, you mentioned sharing data with all levels of staff within the organization. Do you have any ideas of how to educate different levels of staff on the HCAHPS survey data?

Dawn Strawser: Is this for me, Bethany? This is Dawn.

Bethany Wheeler-Bunch: It is, also for you, Dawn.

Dawn Strawser: Yes.

Bethany Wheeler-Bunch: So, do you have any recommendations on how to educate different levels of the staff on the HCAHPS survey data?

Dawn Strawser: Yes. Usually the nursing floors have an area that they post education information for their nurses. Putting up the trend for that specific floor, you can compare to other floors. You can compare to the whole hospital. But the floors really need to see what their specific HCAHPS scores are. It

can be done on staff meetings, various areas, that they can post the information also. I think that's all I have, Bethany.

Bethany Wheeler-Bunch: Okay. Thank you, Dawn. One last question for you. From working with your hospitals, do you have any recommendations that a larger hospital might take to improve HCAHPS rates, since there may be different barriers in between a smaller versus a larger hospital?

Dawn Strawser: Yes. That's a great question. A lot of the strategies I've presented can be done with larger hospitals. I'd like to reach out to some of our larger hospitals to see specifically, but it's basically, you take it floor by floor. You know, what's working on one floor, you can spread that to another floor. The PSA cycles to see what's working, what's not and just making sure that everybody knows, you know, what your scores are. And you can make it a competition too with comparing your units to each other. That's basically what I have. Maybe the other hospitals might have some other recommendations, or anyone else on the line that might have some other thoughts about larger hospitals.

Bethany Wheeler-Bunch: I might pose that to the BFCC team. When you are reviewing the Beneficiary Satisfaction Surveys, do you find that larger hospitals versus smaller hospitals have different barriers? And how would you go about addressing each of those different types of barriers, depending if you're a large or small hospital? Do you have any examples to share?

Rita Bowling: This is Rita Bowling. I don't really have any examples. I just, we look at things more from an individual beneficiary kind of perspective. And sometimes it doesn't really matter whether they're in a big hospital or a large hospital. And I think most of the recommendations that I came, you know, talked about, really could be used by any particular type of facility.

Bethany Wheeler-Bunch: Great. Thank you. Moving on to our next set of questions. These are for Stephanie Smart. So, the first question is, do you discuss HCAHPS rates with your staff? And do you provide any education on the HCAHPS rates and how they're used in CMS programs? And again, that was for Stephanie Smart. I'm thinking Stephanie might be having a few technical

difficulties. So hopefully we can go back to that question when she's able to discuss that again. I'll move on to questions for Jennings now. The first question for Brooke and Allison, did you have any issues with adding information to the EHR after switching back to a paper tool for your bedside shift reporting?

Brooke Hornsby: No, we did not.

Bethany Wheeler-Bunch: Okay.

Allison Fields: We did it on paper and so as we got feedback from the staff, we were able to change it up. It was just a word document as we got feedback. So, we were able to change it very easily for them and got their feedback. So, it worked out for us that way.

Bethany Wheeler-Bunch: Okay. The next question is in reference to Slide 68. Does nurse leader rounding also occur in addition to charge nurse rounding?

Brooke Hornsby: At this time, we do not do leader rounds. The charge nurse rounds on all patients on their floor and our nurse leaders at this time just round on their staff. But we are looking to implement that in the near future.

Bethany Wheeler-Bunch: Great. Thank you. And before moving on to our next question, I just read in the chat window here, another way to share information with staff is town hall meetings that occur quarterly, where senior leadership presents hospital updates, share quality scores in comparison with goals, along with satisfaction scores in comparison with goals. All hospital employees are expected to attend one meeting each quarter. So that's a great suggestion. Thank you for sharing that, Bridget Alexander. The next question for Brooke and Allison. Who schedules the follow up appointments prior to discharge at Jennings?

Allison Fields: We have our unit secretaries in the department that actually call the physician’s office and have them scheduled. And then we pass that information along to the patient on discharge, on when their appointment is. So that way, we can ensure that they keep those appointments.

Bethany Wheeler-Bunch: Thank you. The next question is in regard to Slide 69. What classifies a patient as high risk at discharge?

Brooke Hornsby: It is a survey, actually a questionnaire that our case management, managers do from our, it's a QE health risk screening that they perform, and it identifies our patients that are high risk.

Bethany Wheeler-Bunch: Thank you. And the next question is on slide 70. What is the hospital medicine program?

Brooke Hornsby: Our hospital medicine program is our hospitalists that we have here at the hospital 24/7. And they work in conjunction with our primary care physicians. So, we have both the hospitalists that see patients, and their primary care physicians also see their patients in the hospital.

Bethany Wheeler-Bunch: Great. Thank you.

Allison Fields: Thank you.

Bethany Wheeler-Bunch: Our next set of questions is for Wendy and Stephanie Fry. The first question is in regard to slide, around slide 75. Do hospitals get feedback from the Beneficiary Satisfaction Survey?

Stephanie Fry: This is Stephanie.

Wendy Gary: Go ahead.

Stephanie Fry: Sorry. Go ahead.

Wendy Gary: No. Go ahead.

Stephanie Fry: The survey data are really intended for the internal quality improvement processes. So, on Slide 76, you can see the way that we drew that continuum is that the data (go back to - thanks.) The data go back to the BFCC-QIOs so that they can adjust how they interact with beneficiaries and family members, and also so CMS can help from their perspective in terms of the structure of the program. So, they do not go out to hospitals directly, but rather we work through the BFCC-QIOs to ensure that the

highest possible quality of patient centered interactions is happening with beneficiaries and family members.

Bethany Wheeler-Bunch: Great. Thank you. And before we move on to the next question, I also see another suggestion here in the chat window for education. This is from Eric Bolton. I create a monthly patient experience score card that is shared monthly with all leaders and is presented at multiple meetings, including internal planning meetings and board meetings. So, thank you for that suggestion, Eric. The next question is also for Wendy and Stephanie. Are Beneficiary Satisfaction Surveys only for certain areas?

Stephanie Fry: The surveys are administered or provided to beneficiaries across the country. So, in one of the slides that follows ours, you saw the different service areas for the BFCC-QIOs. And so, we do survey beneficiaries all the way across the country.

Bethany Wheeler-Bunch: Thank you. And then one final question for your team. What is the time-frame for the survey? Specifically, I'm trying to determine if billing would have any impact on the patient's perception.

Stephanie Fry: The surveys, we try to do as close to real time surveying as we possibly can. And so, at the end of each month, we sample from among all closed cases. So, for some beneficiaries, I guess it could be up to a full month before they receive their surveys. And for other people, it would be sort of within a week of their case being closed. So, it just depends on where they fall in that month time-frame. But it is a pretty quick process from the time the case is closed to the time the survey is sent out.

Wendy Gary: And this is Wendy. I just want to add as well that a billing issue may generate an appeal or a complaint to the BFCC-QIO who would then, that beneficiary would then become, you know, eligible for the survey if they one, agree to it, and two, they were eligible based on our eligibility criteria. And then they were selected or sampled into the survey sample.

Bethany Wheeler-Bunch: Great. Thank you. Our next question is for Elena and/or Rita. How do we obtain the education on appeal?

Elena Krafft: So actually, on the slide on 78, I believe that's my slide, I have a link listed there for the National Centered Care Initiatives. If you go there and click on Contact Us, we can then coordinate that with you, with both QIMs. The one before this, the BFCC-NCC, slide. Yes. So, this link here on the slide, and then just click on Contact Us and then just any request that you have for additional education, you can send it that way.

Bethany Wheeler-Bunch: Great. Thank you. And I think we can take two more questions today, and they are actually both for Dr. Lehrman. The first one is, could you please repeat what you said about pain management? Did I hear you correctly say that the measure will continue to be reported until December of 2018?

Dr. William Lehrman: Yes. That's correct. The pain management items will be publicly reported or the measure, will be publicly reported through the October 2018 *Hospital Compare* refresh. And that means they will be in *Hospital Compare* until we refresh again in December. So essentially the original pain management composite measure will be on *Hospital Compare* into December of this year. At that point, it will be removed from *Hospital Compare.*

Bethany Wheeler-Bunch: Great. Thank you. And a follow up question as well is, how can we receive HCAHPS scores by unit? Do you have any ideas on that Dr. Lehrman?

Dr. William Lehrman: Okay. Yes. We get this question a lot. I'd like to re-emphasize that HCAHPS is a hospital survey. It's meant to reflect care in the entire hospital. Some hospitals, using their own data, they break it down by floor or ward, even individual practitioner, doctor, or nurse. That has lots of risks to it because the questions are made about, the questions are about the entire hospital experience. And especially when we're talking about doctors and nurses, we don't differentiate doctor this or doctor that. It's about all doctors, all nurses. Hospitals can, if they sample enough, create enough data for a ward or a floor to get reliable results. We have information in our HCAHPS Quality Assurance Guidelines, QHE, which is located on HCAHPS online website, about sampling methods that can be used to get valid scores for wards or floors or some unit within a

hospital. But essentially, you have to have enough sample to get reliable, enough surveys, completed surveys to get reliable results for some kind of unit within the hospital like a ward or a floor.

Bethany Wheeler-Bunch: Thank you Dr. Lehrman. And that is all the time that we have today for questions. I want to thank you again for joining our webinar today. I hope that the information will be useful for you as you are improving your own patient experience of care at your hospitals. I will now pass it over to Dr. Debra Price to present on continuing education. Everyone, have a great rest of your day.

Dr. Debra Price: Well, hello and thank you for allowing me time to go over these credits. Today's webinar has been approved for 1.5 continuing education credits by boards listed on this slide. We are now a nationally accredited nursing provider. And as such, all nurses report their own credits to the board using the national provider number 16578.

We now have an online CE certificate process. You can receive your certificate two different ways. First way is if you registered for the webinar through ReadyTalk®, a survey will automatically pop up when the webinar closes. The survey will allow you to get your certificate. And the second way to receive your certificate is within 48 hours, your host will be sending out another survey link. If there's other people in the room that are listening to this event, this is the time that you can send the link to them.

If you do not immediately receive a response to the email that you signed up with in our learning management center, that means you probably have a firewall that's blocking our automatic link. If that's the case, please go back and use a New User link and use your personal email, as well as your personal phone number.

This is what the survey will look like at the end of this event. It will pop up, and again will be sent to all attendees within 48 hours. In the bottom, you notice the gray done box. Click that and this is the page that's going to pop up. You notice that there are two links on this page, the New User link and Existing User link. If you've been having certificates all along and

haven't had any problems, please click on the Existing User link. If you have had problems, that's when we'd like you to use the New User link and input your personal email, as well as a personal phone number.

This is what the New User slide will look like. You put in your first name, your last name and your personal email and personal phone number. And this is what the Existing User slide will look like. Your user name is your complete email address, including what's after the @ sign. And your password is whatever you used to sign up. If you forgot your password, it’s okay. Just click in that box and you will be prompted what to do next. And now I thank you for attending the webinar. I hope that you learned something and please enjoy the rest of your day.